MONTANA
Department of Public Health & Human Services

ANNUAL SURVEY OF LONG-TERM CARE FACILITIES 2005

PLEASE RETURN THIS SURVEY NO LATER THAN JANUARY 31, 2006.

Mail or fax a typed or clearly printed copy to: Department of Public Health & Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953, Fax 444-1742.

Name and Address of Facility:

E-Mail Contact:

Please refer to the instructions on pages 5 and 6 of this survey.

A. REPORTING PERIOD

Report data for a full 12-month period (365 days).

1. Indicate reporting period used:

   Beginning _____/_____/_____ and ending _____/_____/_____

2. Was the facility in operation 12 full months at the end of the period? ☐ Yes ☐ No

B. CLASSIFICATION

1. NOT FOR PROFIT FOR PROFIT

2. a. Please name owner of facility (county, corporation, etc.)

   b. Please name management firm of facility (N/A if management is not provided through contract)

3. a. Is the facility operated as part of a chain, whether for profit or not?

   ☐ Yes ☐ No

   b. If YES, please give the name and address of the PARENT organization.

C. UTILIZATION OF BEDS AND SERVICES

1. Licensed bed capacity: _____
2. Number of beds currently set up and staffed for use: _____
3. Utilization data (a + b - c - d = e):
   - a. Total number of patients on first day of reporting period: _____
   - b. Total number of patients admitted during year: _____
   - c. Total number of patients discharged during year (exclude deaths): _____
   - d. Total number of patient deaths during year: _____
   - e. Total number of patients remaining on last day of reporting period: _____
4. Long-term care patient days of service:
   - a. Total Medicare patients days _____
   - b. Total Medicaid patient days _____
   - c. Total Other patient days _____
   - Total (sum of a, b, and c) _____
5. Total by age and sex for all patients admitted during the survey year:

Age Group	**Female**	**Male**	**Totals**
Under 65	_____	_____	_____
65 - 74	_____	_____	_____
75 - 84	_____	_____	_____
85 +	_____	_____	_____
TOTAL (All ages)	_____	_____	_____

D. FINANCIAL DATA

If actual figures are not available, please estimate (indicate which figures have been estimated). Round to the nearest dollar.

1. Total annual operating expenses from most recent financial statement
   - a. Total gross revenue $_____
   - b. Payroll expenses $_____
   - c. Non-payroll expenses $_____
   - d. Total expenses $_____
2. Closing date of financial statement: _____/_____/_____
3. Breakdown of facility's operating revenues (**in percentages**):
   - a. Medicare _____%
   - b. Medicaid _____%
   - c. Private Pay _____%
   - d. Insurance _____%
   - e. Grant Funds _____%
   - f. Contributions _____%
   - g. Others _____%
   - **TOTAL** _____% (**MUST EQUAL 100%**)

E. PERSONNEL DATA

Combined facilities report only personnel for long-term care.

		FULL-TIME (35 HR/WK)	**PART-TIME** (<35 HR/WK)
1.	RNs	_____	_____
2.	LPNs	_____	_____
3.	AIDES	_____	_____
4.	ADMINISTRATION	_____	_____
5.	OTHER	_____	_____
6.	TOTAL EMPLOYEES (All Categories)	_____	_____

F. PATIENT ORIGIN DATA (Total should equal C.3.b., Admissions)

COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL
Beaverhead		Hill		Ravalli	
Big Horn		Jefferson		Richland	
Blaine		Judith Basin		Roosevelt	
Broadwater		Lake		Rosebud	
Carbon		Lewis & Clark		Sanders	
Carter		Liberty		Sheridan	
Cascade		Lincoln		Silver Bow	
Chouteau		Madison		Stillwater	
Custer		McCone		Sweet Grass	
Daniels		Meagher		Teton	
Dawson		Mineral		Toole	
Deer Lodge		Missoula		Treasure	
Fallon		Musselshell		Valley	
Fergus		Park		Wheatland	
Flathead		Petroleum		Wibaux	
Gallatin		Phillips		Yellowstone	
Garfield		Pondera		Unknown/In-State	
Glacier		Powder River		Out-of-State	
Golden Valley		Powell			
Granite		Prairie		**TOTAL** **(Must Equal C.3.b.)**	

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Date Survey Completed _____/_____/_____

ADMINISTRATOR'S NAME (type or print)

ADMINISTRATOR'S SIGNATURE

If we have questions about any of the responses on this survey, whom should we contact?

NAME **TELEPHONE**

If you have any questions, please contact the Certificate of Need Program, Montana Department of Public Health and Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742, or E-mail psourbeer@mt.gov

Thank you!

INSTRUCTIONS LONG-TERM CARE FACILITIES 2005

Address: Please write the name and address of the facility on Page 1 of the survey.

Copies: Mail or fax a typed or clearly printed copy to: Department of Public Health and Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. **Keep a copy of the survey for your files**.

Note: Answer every item. Enter "O" to mean none.

A. REPORTING PERIOD

The preferred reporting period is January 1, 2005, through December 31, 2005. It is permissible to use a different 12-month period, but please be consistent from year to year, and indicate the time period used.

B. CLASSIFICATION

1. The following definitions apply to this section of the survey:

Not For Profit:	Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
For Profit (Proprietary):	Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

2. Please indicate the governmental entity (state, city, county or federal), corporation, company, etc., responsible for the ownership and management of the agency.

C. UTILIZATION OF BEDS AND SERVICES. Report utilization for a full 12-month period.

1. "Licensed bed capacity" should include the number of beds licensed on the last day of the reporting period. To facilities that have shifted some beds to personal care designation, report ALL BEDS, nursing home and personal care combined.

2. To facilities that have shifted some beds to personal care designation, report ALL BEDS, nursing home and personal care combined.

3. To facilities that have shifted some beds to personal care designation, report NO personal care patients whatsoever in any of this section.
   b. A change from one level of care to another does not count as a new admission.
   e. The following formula should be used to verify the numbers reported in this section:
      a + b - c - d = e, "Total number of residents remaining on the last day of the reporting period."

4. To facilities that have shifted some beds to personal care designation, report NO personal care patient days whatsoever in any of this section.

Total patient days of service is calculated as follows:
Total number of patients who stayed at least one day in the facility during the one-year reporting period, MULTIPLIED BY the number of days they were there, EQUALS the Total patient days of service.

EXAMPLE:
5 Medicare patients X 10 days = 50 Medicare patient days of service
3 Medicaid patients X 90 days = 270 Medicaid patient days of service
1 Other patients X 365 days = 365 other patient days of service
Total days = 685 Total Patient Days of Service

Note: For purposes of this section, a Medicare patient day is one for which the facility is reimbursed in total or in part by Medicare. A Medicaid patient day is one for which the facility is reimbursed in total or in part by Medicaid. If both Medicare and Medicaid reimburse the facility, count the day as a Medicare patient day. "Others" are those days for which the facility is paid by any means other than Medicare or Medicaid.

5. To facilities that have shifted some beds to personal care designation, report NO personal care patients whatsoever in any of this section.

D. FINANCIAL DATA. Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures have been estimated). Please do not use "N/A" in this section. Round all figures to the nearest dollar.

1. a. Total gross revenue: Includes total revenues from direct patient care and all other sources.
   b. Payroll expenses: Report salaries for full-time and part-time personnel as reported in section E, Personnel Data.
   c. Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Compare financial data with 2004 Annual Survey financial data and explain any differences exceeding 10%.

E. **PERSONNEL DATA**. Exclude volunteers and all personnel whose salary is financed entirely by outside research grants.

For combined facilities, report **ONLY** the personnel for the long-term care facility.

F. **PATIENT ORIGIN DATA**. Report all residents admitted to the facility for the reporting year by county of origin. **(Total reported in patient origin must equal C.3.b.).**

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